STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555765	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hills Post Acute	1800 Old Tustin Avenue Santa Ana, CA 92705

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the nutritional needs were addressed for one of five sampled residents (Resident 2). * Resident 2 was observed with Nepro (specialized, calorie-dense nutritional shake) and Ensure (nutritional supplement) at his bedside table without a physician's order. This failure placed the resident at risk to receive nutritional supplements unnecessarily. Findings: Medical record review for Resident 2 was initiated on 6/30/26. Resident 2 was readmitted to the facility on [DATE]. Review of Resident 2's MDS assessment dated [DATE], showed Resident 2 was cognitively intact. On 6/30/26 at 1000 hours , during an observation and concurrent interview with Resident 2 in his room, seven cartons of 237 ml vanilla flavored Nepro and one carton of 237 ml vanilla flavored Ensure were found at Resident 2's bedside table. When Resident 2 was asked, who the Nepro and Ensure were for, Resident 2 stated it was his drinks. When asked who provided the Nepro and Ensure, Resident 2 verified it was the facility staff who supplied him the Nepro and Ensure to drink. On 6/30/26 at 1030 hours, an observation and concurrent interview for Resident 2 was conducted with LVN 3. LVN 3 verified the presence of seven cartons of 237 ml vanilla flavored Nepro and one carton of 237 ml vanilla flavored Ensure at Resident 2's bedside table. LVN 3 further verified they were nutritional supplements for Resident 2. On 6/30/26 at 1030 hours, an interview and concurrent review of Resident 2's Order Summary Report dated 6/2026 was conducted with LVN 3. The Order Summary Report failed to show documented evidence the Nepro and Ensure supplements were ordered by the physician. LVN 3 stated the orders for the Nepro and Ensure supplements were discontinued. On 6/30/26 at 1330 hours, an interview and concurrent medical record review for Resident 2 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated a physician's order was needed before giving Resident 2 the Nepro and Ensure as supplements. On 6/30/26 at 1430 hours, an interview was conducted with the DON. The DON was informed of the above findings and acknowledged the findings.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555765	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hills Post Acute	1800 Old Tustin Avenue Santa Ana, CA 92705

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary pharmaceutical services for one of five sampled residents (Resident 5). * The facility failed to administer the potassium chloride (medication used to treat and prevent hypokalemia-low potassium level) medications according to the pharmacy-related directions for Resident 5. This failure had the potential to put the resident at risk for adverse consequences related to the medication use. Findings: Review of the facility's P&P titled Guidelines for Medication Administration (undated) showed if a discrepancy exist or you are unfamiliar with the medication, consult the appropriate resources such as the pharmacist. On 6/29/26 at 1025 hours, a medication administration observation for Resident 5 was conducted with LVN 2. During the medication administration, LVN 2 was observed popping the potassium chloride (mineral supplement primarily used to treat or prevent low blood potassium levels) medication from the bubble pack into a 10 ml cup. LVN 2 then read out loud the potassium chloride bubble pack instructions to dissolve the two tablets in four oz. water and administer by mouth one time a day for supplement, do not crush or chew the tablet. LVN 2 then proceeded with handing the medication and a cup of water to Resident 5. LVN 2 was not observed following the pharmacy related directions shown in Resident 5's potassium chloride extended release 20 mEq bubble pack. On 6/29/26 at 1030 hours, an interview and concurrent review of the pharmacy related directions for potassium chloride extended release 20 mEq bubble pack was conducted with LVN 2. The pharmacy related instructions in Resident 5's potassium chloride extended release 20 mEq bubble pack showed a direction to dissolve two tablets in four oz. of water. However, LVN 2 was not observed dissolving the two tablets of potassium chloride in four oz of water as directed. LVN 2 stated she followed the physician's order and not the pharmacy related directions. Medical record review for Resident 5 was initiated on 6/29/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's Order Summary Report for 6/2026 showed a physician's order dated 6/17/26, to administer potassium chloride extended release 20 mEq to give two tablets by mouth one time a day for supplement. Review of Resident 5's MDS assessment dated [DATE], showed Resident 5 was cognitively intact. On 6/20/26 at 1430 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and facility P&P review, the facility failed to ensure the appropriate infection control practices were followed for one of five sampled residents (Resident 4). * LVN 1 failed to perform hand hygiene after the removal of gloves post cleaning of a glucometer (a machine to measure blood sugar level) and a medication tray. This failure posed the risk of spreading infectious organism to the residents in the facility. Findings: Review of the facility's P&P titled Hand Hygiene revised 5/2026 showed hand hygiene is a general term that applied to handwashing, antiseptic hand wash, and alcohol-based hand rub. Hand washing is the vigorous, brief rubbing together of all surfaces of hands with soap and water, followed by rinsing under a stream of water. Alcohol-based hand rub is a 60-95 percent ethanol or isopropyl alcohol-containing preparation base designed for application to the hands to reduce the number of viable microorganisms. Procedure included using an alcohol-based hand rub containing at least 62% alcohol; or alternatively, antimicrobial or non-antimicrobial soap and water after removing gloves. On 6/30/26 at 1226 hours, during the medication administration observation for Resident 4, LVN 1 was observed wearing gloves while cleaning a glucometer and a medication tray. After cleaning the glucometer and medication tray, LVN 1 removed the old gloves and immediately put on new pair of gloves. Hand hygiene was not observed before and after removing the contaminated gloves. LVN 4 proceeded to obtain the blood sugar of Resident 4 by performing the finger prick. On 6/29/26 at 1400 hours, an interview was conducted with LVN 1. When asked about the policy on hand hygiene, LVN 1 stated the nurses should wash hands before and after using gloves. When asked if he performed hand hygiene in between glove use when checking Resident 4's blood sugar, LVN 1 stated he did not. LVN 1 further stated the correct process would be to perform hand hygiene in between every activity including donning on new gloves and removing dirty gloves. On 6/30/26 at 1025 hours, the ADON was informed and acknowledged the above findings. On 6/30/26 at 1330 hours, RN 1 was informed and acknowledged the above findings.